This form may be completed online, printed and mailed to the address listed below.

ATTACHMENT A

STATE OF NEBRASKA
Department of Health and Human Services
Regulation and Licensure - Credentialing Division
P.O. Box 94986, Lincoln, Nebraska 68509-4986
402-471-2117

PSYCHOLOGY APPLICATION FOR A LICENSE

Please Type or Print Clearly
It is your responsibility to submit or request to have submitted all required supporting documents.
Failure to do so could result in a delay in processing your application.

SECTION A – DEMOGRAPHIC INFORMATION (All applicants must complete this section) (***Your name, address, date of birth, and school information is public information and will appear on the internet*** www.hhs.state.ne.us/lis/lisindex.htm***)***

Applicant's Name:	First	Middle/MI:	Last:
Public Address:	Street/PO/Route		
	City	State	Zip Code
Telephone Number:	# during normal business hours		
Social Security Number: (this is NOT public information and will not be on the Internet) It is required for child support enforcement purposes; and for potential disclosure of reportable actions to the Federal department of Health and Human Service's Healthcare Integrity and Protection Data Bank (HIPDB)			SS#:
Place of Birth:	City/State/Country	Date of Birth (Month/Day/Year)	
(If your official transcript does not verify your date of birth, submit a copy of birth or marriage certificate, or driver's license, or similar documentation)			

SECTION B - LICENSURE APPLICATION CATEGORY (All applicants must complete this section) Check the appropriate process by which you are applying for Licensure as a Psychologist.

1	❒	**RECIPROCITY** (Applicants must take the Nebraska Board-developed Examination)	**FEE: See Chart**
	❒	ASPPB Certificate of Professional Qualification (CPQ)	
	❒	ASPPB Reciprocity Agreement	
	❒	Health Service Provider by National Register of Health Service Providers (at doctoral level)	
	❒	TEMPORARY LICENSE **APPLICABLE TO RECIPROCITY ONLY – Check this box if** you wish to be issued a temporary license to practice up to one year pending successful passage of the Nebraska Board-developed Examination	**FEE: $25.00**
2	❒	INITIAL LICENSURE IN NEBRASKA **BASED ON DOCTORAL DEGREE IN PSYCHOLOGY** (APA or Equivalent) and completion of 2 years of supervised professional experience (Applicants must take OR have taken the EPPP Examination and Nebraska Board-developed Examination)	**FEE: See Chart**
3	❒	**SPECIAL LICENSURE TO LICENSURE** and completion of two years of supervised professional experience	**FEE: $50.00**
4	❒	**APPLICATION BASED ON CERTIFICATION WITH AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY** (Applicants must take the Nebraska Board-developed Examination)	**FEE: See Chart**

FEE: Determine the month and year in which you are submitting your application by using the chart below. You will note the fee from July to December is a lesser fee; this is due to the statutes which state: "when a credential will expire within 180 days after its initial issuance date, the Department will collect $25 and the Licensee Assistance Program fee of $1, and the credential will be valid until the next subsequent renewal date".

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even Numbered Year	**$51**	**$51**	**$51**	**$51**	**$51**	**$51**	**$26**	**$26**	**$26**	**$26**	**$26**	**$26**
Odd Numbered Year	**$52**	**$52**	**$52**	**$52**	**$52**	**$52**	**$52**	**$52**	**$52**	**$52**	**$52**	**$52**

Make payable to: CREDENTIALING DIVISION

NOTE: Licenses expire 01/01 of odd years

SECTION C – EPPP EXAMINATION: If you have taken the Examination for Professional Practice of Psychology (EPPP) in a State other than Nebraska, you must complete this section.

If you have taken the Examination for Professional Practice of Psychology (EPPP) in a State other than Nebraska, you must submit an official copy of the examination scores from the Professional Examination Service, 475 Riverside Drive New York, New York 10125 OR you may submit official verification of the examination results from the State Licensing Board where the test was administered.

Date of Examination:	
City and State where Examination was administered:	

SECTION D – CONVICTION INFORMATION/OTHER STATE LICENSURE: All applicants must complete this section

Questions	Yes	No	Type of Crime or Licensure Action	Date of Action	Name of Court (City/County/State) or Entity taking Action
Have you ever been convicted of a misdemeanor or felony?	❒	❒			

If you answered YES to any of the questions above, you must request the following documents be sent directly to this office:

- Official Court Record, which includes charges and disposition
- Arrest Records
- All addiction/mental health evaluations (if the conviction involved a drug and/or alcohol related offense)
- If you are/were on probation, a letter from your probation officer referencing your probationary progress or date of release
- A letter from the applicant explaining the nature of the conviction

Questions	Yes	No			
Are you licensed or certified in another state?	❒	❒	If yes, what State are you licensed in?		What type of license do you hold?
Have you ever surrendered your license or certification?	❒	❒	Type of Licensure Action	Date of Action	Name of Entity taking Action
Has action been taken to suspend or revoke your license or certification?	❒	❒	Type of Licensure Action	Date of Action	Name of Entity taking Action

If you answered YES to any of the questions above, you must request the following documents be sent directly to this office:

- Official Documents from the State Board in which the disciplinary action was taken
- Certification of your license/certificate in another state (Attachment A3).

You **<u>are not required to complete</u>** this section (Section E) if you are applying based on: **CPQ**, **ASPPB Reciprocity Agreement**, or a current credential at the doctoral level as a **Health Service Provider by the National Register of Health Service Providers**. However, you must submit evidence of your current certification or credential.

SECTION E – INTERNSHIP EXPERIENCE: All applicants must complete this section and submit ATTACHMENT A4 verify this information. An applicant is required to have completed two years of supervised professional experience. One year shall be an internship meeting the standards of accreditation adopted by the American Psychological Association, and one year shall be supervised postdoctoral experience (SECTION F and ATTACHMENT A5).

	INTERNSHIP EXPERIENCE:				
1	Facility when Internship completed	Name:			
2	Address	Street/PO/Route:			
		City:	State:	Zip:	
3	Dates of Internship	From (m/d/y):		To (m/d/y):	
4	Name of Supervisor	First:	Middle/MI:	Last:	
5	Credentials of Supervisor	State/Jurisdiction Licensed:	Type of License:	License Number:	
6	Was the internship APA approved?			Yes ❒	No ❒
	(If the internship is <u>not</u> accredited by APA, you must submit evidence that the internship meets the standards of accreditation adopted by APA – YOU MUST COMPLETE THE <u>INTERNSHIP EQUIVALENCY FORM</u>				
7	Below, provide a brief statement of the services you provided during your internship:				

You **<u>are not required to complete</u>** this section (Section F) if you are applying based on: **CPQ**, **ASPPB Reciprocity Agreement**, or a current credential at the doctoral level as a **Health Service Provider by the National Register of Health Service Providers**.

SECTION F – POSTDOCTORAL SUPERVISED EXPERIENCE: If you have not completed the postdoctoral supervised experience, attachment a5 must be submitted at the conclusion of such experience - you may also submit the licensure fee at that time.

SUPERVISED POSTDOCTORAL EXPERIENCE:

1	Is a supervisory registration form on file with the Department - Note: Title 172, Chapter 155, Sections 002.32 and 002.33 require Individuals who are completing one year of supervised postdoctoral experience to submit a supervisory registration form **prior** to commencement of the experience or practice.			Yes ❒	No ❒
2	❒	I am currently completing the supervised postdoctoral experience - **Attachment A5 must be completed by your supervisor and submitted upon completion of the experience**			
		Anticipated Completion Date:			
	OR				
	❒	I have completed the supervised postdoctoral experience			
3	Name of Facility where experience completed or will be completed:	Name:			
4	Address:	Street/PO/Route:			
		City:	State:	Zip:	
5	Dates of Experience:	From (month/day/year):	To (month/day/year:		
6	Name of Supervisor:	First:	Middle/MI:	Last:	
7	Credentials of Supervisor:	State/Jurisdiction Licensed:	Type of License:	License Number:	
8	Below, provide a brief statement of the services you provided during your supervised post doctoral experience:				

You **are not required to complete** this section (Section G) if you are applying based on: **CPQ**, **ASPPB Reciprocity Agreement**, or a current credential at the doctoral level as a **Health Service Provider by the National Register of Health Service Providers**.

SECTION G – LICENSURE ISSUED ON THE BASIS OF A LICENSE IN ANOTHER JURISDICTION (Complete this section if you hold a license to practice Psychology in another jurisdiction and are applying for licensure based on this license.)							
1	Name of Agency Issuing License						
2	Date Issued:		License Number:				
3	Have you been in an accepted residency or graduate program for one year of the three years immediately preceding the date of an application for Nebraska license?					Yes ❒	No ❒
	3A	If in an accepted residency or graduate program, provide the name of the facility or graduate program, address, and dates actively engaged in the practice of psychology. (Use an additional sheet if space is inadequate.)					
		Facility/Graduate Program Name:	Name:				
		Address	Street/PO/Route:				
			City:	State:	Zip:		
		Dates engaged in Practice:	From (month/day/year):	To (month/day/year:			
4	Have you been in active and continuous practice of psychology under license by examination in the state, territory, or District of Columbia from which you come for **at least one year following the issuance of such license**?					Yes ❒	No ❒
	Have you been in the active and continuous practice of psychology under such license **for one year of the three years immediately** preceding the date of an application for Nebraska license?					Yes ❒	No ❒
	4A	Give location, address, and dates actively engaged in the practice of psychology. (Use and additional sheet if space is inadequate.)					
		Facility Name:	Name:				
		Address:	Street/PO/Route:				
			City:	State:	Zip:		
		Dates engaged in Practice:	From (month/day/year):	To (month/day/year:			
		Facility Name:	Name:				
		Address:	Street/PO/Route:				
			City:	State:	Zip:		
		Dates engaged in Practice:	From (month/day/year):	To (month/day/year:			
5	Have you requested a certification ***(Attachment A3)*** of your psychology license sent to Nebraska?					Yes ❒	No ❒

If you have **previously submitted** your official transcript, **OR** if you are applying based on: **CPQ**, **ASPPB Reciprocity Agreement**, or a current credential at the doctoral level as a **Health Service Provider by the National Register of Health Service Providers**, **you are not required to complete this section (Section H)**

SECTION H – EDUCATION: All applicants must complete this section and cause to be submitted an Official Transcript of a Doctoral Degree in Psychology; you need only submit information relative to your doctoral degree. You must possess a doctoral degree from a program of graduate study in professional psychology from an institution of higher education. The degree shall be obtained from a program of graduate study in psychology that meets the standards of accreditation adopted by the American Psychological Association. Any applicant from a doctoral program in psychology that does not meet such standards shall present a certificate of retraining from a program of respecialization that does meet such standards.

YOUR TRANSCRIPT MUST BE SENT DIRECTLY FROM THE INSTITUTION TO THE CREDENTIALING DIVISION (address on page 1 of application)

1.	Last Name on Transcript:				
2.	Institution Name:				
3.	Institution Address:	Street/PO/Route:			
		City:	State:	Zip:	
4.	Graduation Information:	Date (month/day/year):	Degree:	Major:	
		Is the program of graduate study in psychology accredited by the American Psychological Association (APA)?		Yes ❑	No ❑
		If the program is not APA accredited, name the accrediting body:	Name:		
(If the program is not accredited by APA, you must submit evidence that the program meets the standards of accreditation adopted by APA – YOU MUST COMPLETE THE PROGRAM EQUIVALENCY FORM)					

SECTION I - ATTESTATION (All applicants must complete this section of the application)

I hereby state that I am the person making application, I am of good moral character, and the statements on this application are true and complete.

I further state that:

❑ I have not practiced Psychology without a license in Nebraska prior to this application for licensure; **or**

❑ I have practiced Psychology without a license/registration prior to this application for licensure (does not include internship time or if you were licensed as a provisional or registered as a psychological assistant/associate).

____ number of days in Nebraska prior to July 1, 2004
____ number of days in Nebraska after July 1, 2004

_____
(Signature of Applicant)

_____ date

STATE OF NEBRASKA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE - Credentialing Division
P.O. Box 94986
Lincoln, Nebraska 68509-4986
402-471-2117

RECIPROCITY

CERTIFICATION OF PSYCHOLOGY LICENSURE

(Must be completed by certifying/licensing agency in the State in which you are licensed)

(Print or Type)

Our records indicate that _____ was licensed as a Psychologist on

_____ and was issued license number _____ such license expires _____. Was the license
(month/day/year) (month/day/year)

issued on the basis of a written examination? ❑ yes ❑ no

Name of Examination:	
Date Tested:	
Applicant's Raw Score:	
Applicant's Percent Score:	

(If a written examination was not required, attach copies of the documentation required for a license.)

It is further verified that based on the records in this Department, the applicant's license has:

a) been suspended, yes ❑ no ❑

b) been revoked, yes ❑ no ❑ If yes to any of these questions, please explain:

_____

_____

and c) has been maintained in good standing up to and including the present date, yes ❑ no ❑; and that so far as the records of this agency are concerned, the applicant is entitled to the endorsement of this agency.

Date: _____

_____
Signature (No Stamp)

_____
Name and Title

OPTIONAL:
Telephone Number: _____
Area Code

_____
Licensing Agency

_____
Address

(S E A L)

_____
City/State/Zip Code

www.hhs.state.ne.us/crl/mhcs/psych/psychapp.pdf

STATE OF NEBRASKA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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VERIFICATION OF INTERNSHIP IN PSYCHOLOGY

This form must be completed by the internship supervisor

I, _____ verify that _____has completed a
(Supervisor's Name) (Applicant's Name)

❒ full-time	❒ part-time	internship under my supervision for _____ hours of supervision per week, during the following time:
Date Began(month/day/year):		Date Ended (month/day/year):
and earned _____ total hours of experience.		

Internship was completed at:	Name of Facility:		
Address:	Street/PO:		
	City:	State:	Zip:
Dates engaged in Practice:	From (month/day/year):	To (month/day/year:	

1	Nature of services provided by applicant:
2	Describe the interaction which occurred between interns and applicant:
3	Describe the range of supervised experience by the applicant in:
	Assessment:
	Intervention:
	Research into the applications of psychology:

4	Staff names, degrees, state of licensure/certification and license/certification number:			
	Name	Degree	State of Licensure	License Number
5	Describe the patient population of the facility:			

Other Comments

Signature of Supervisor

License Number

(OPTIONAL) Telephone Number

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VERIFICATION OF POSTDOCTORAL EXPERIENCE IN PSYCHOLOGY

This form must be completed by the supervisor for the postdoctoral experience claimed by the applicant.

I, _____ verify that _____ has completed at least one year of
(Supervisor's Name) (Applicant's Name)
postdoctorate experience under my supervision.

If the postdoctoral experience is to be earned in Nebraska, it must be:

(1) Registered with the Department prior to commencement in accordance with 172 NAC 155-003.02;
(2) Under the supervision of a licensed psychologist (a special licensed psychologist can not supervise);
(3) 1,500 or more hours in total duration, including 1,000 or more hours of direct service hours earned in not more than 24 months;
(4) Meets the standards of supervision specified in 172 NAC155-002; and
(5) Compatible with the knowledge and skills acquired during formal doctoral or postdoctoral education in accordance with professional requirements and relevant to the intended area of practice;

If the postdoctoral experience is earned outside of Nebraska, it must be:

(1) Under the supervision of a licensed psychologist or similar title in said state;
(2) 1,500 or more hours in total duration, including 1,000 or more hours of direct service hours earned in not more than 24 months; and
(3) Compatible with the knowledge and skills acquired during formal doctoral or postdoctoral education in accordance with professional requirements and relevant to the intended area of practice.

Direct Service means a variety of activities, during the internship and/or post doctoral experience, associated with a client system, including collateral contacts, for purposes of providing psychological services.

Examples of direct services are:

1. Interviewing;
2. Therapy;
3. Case Conferences;
4. Behavioral Observations and Management;
5. Evaluations;
6. Treatment Planning;
7. Testing;
8. Consultations; and
9. Biofeedback.

Examples of Non-Direct Services are:

1. Insurance/Managed Care Reviews Relating to Payment Judgements;
2. Class Room Teaching;
3. Supervising Provisionally Licensed Mental Health Practitioners; and
4. Receiving Supervision.

Experience was completed at:	Name of Facility:		
Address:	Street/PO:		
	City:	State:	Zip:
Dates of Experience:	From (month/day/year):	To (month/day/year:	
Hours of service:	Direct Service Hours:	Total Hours:	

1	Provide a brief description of the nature of services provided and population served by the applicant:
2	Describe the nature of supervision received by applicant:

Other comments:

Signature of Supervisor

License Number

(OPTIONAL) Telephone Number